Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

October 26, 2010

Mr. Neville Wise, Acting Commissioner
Cabinet for Health and Family Services
Departmart for Mediciad Services
275 E. Main Street, 6W-A
Frankfort, KY 40621

Re: Kentucky Title XIX State Plan Amendment, Transmittal #10-009

Dear Mr. Wise:

We have reviewed Kentucky State Plan Amendment (SPA) 10-009, which was submitted to the Atlanta Regional Office on October 18, 2010. This amendment updates the Kentucky State Plan with the name of the Acting Medicaid Director.

Based on the information provided, we are pleased to inform you that Kentucky SPA 10-009 was approved on October 25, 2010. The effective date is October 1, 2010. The signed CMS-179 and the approved plan pages are enclosed. If you have any questions regarding this amendment, please contact Laura Killebrew at (404) 562-0151.

Sincerely,

for Jackie L. Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 10-009

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430.12(b)

7. FEDERAL BUDGET IMPACT:
a. FFY 2005 $0
b. FFY 2006 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page 89

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
State Governor's Review

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Neville J Wise

13. TYPED NAME: Neville Wise

14. TITLE: Acting Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 10/15/2010

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 10-18-10

18. DATE APPROVED: 10/25/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/10

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS:

FORM HCFA-179 (07-92)